Appendix H

NOAA Health Services Questionnaire

Name

_____ _____ ___ Program _____

Last First Mi Position _____

Birth Date ___/___/___ mm dd yy

Work Address _____ _____ _____

Phone W _____ H _____

Sex: M☐ F☐

HEALTH INFORMATION

General State of Health: Excellent☐ Good☐ Fair☐ Poor☐

Presently under the care of a physician? No☐ Yes☐

Month/Year of most recent Physical Exam? ___/___

List current medications (prescription and non-prescription):

None☐

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

List Allergies :

None☐

	Allergy	Reaction
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

List ALL active health problems:

None☐

1. _____
2. _____
3. _____
4. _____

Major Surgeries / Hospitalizations / Emergency Room visits

None☐

	Year	Reason
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

List Any Dietary Restrictions:

None☐

	Restriction	Reason
1.	_____	_____
2.	_____	_____

Return to TAS Web Site

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NOAA Health Services Questionnaire

GENERAL SCREENING

As an adult, have you had or experienced?

	No	Yes		No	Yes
Cancer	☐	☐	Severe Depression	☐	☐
Tuberculois	☐	☐	Paralysis	☐	☐
Asthma	☐	☐	Epilepsy	☐	☐
Hepatitis	☐	☐	Impaired Mobility	☐	☐
Chronic Cough	☐	☐	Severe Hearing Loss	☐	☐
Coughed up Blood	☐	☐	Severe Visual Impairment	☐	☐
Recent unexplained gain or loss of 20 or more lbs.	☐	☐	Periods of Unconsciousness	☐	☐
			Severe Motion Sickness	☐	☐

Please explain all YES answers:

_____

_____

_____

_____

_____

_____

CARDIAC SCREENING

As an adult, have you had or experienced?

	No	Yes		No	Yes	(and value if known)
Abnormal ECG	☐	☐	Hypertension	☐	☐	recent reading _____
Sedentary Life Style	☐	☐	Diabetes	☐	☐	HgA_{1C} _____
Family History of Heart Attack before age 45	☐	☐	High Cholesterol	☐	☐	recent reading _____
			Tobacco Use	☐	☐	packs/day _____
Heart Attack	☐	☐	Prolonged Chest Pain	☐	☐	
Shortness of Breath	☐	☐	Fainting spells/Syncope	☐	☐	

Please explain all YES answers:

_____

_____

_____

_____

_____

_____

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NOAA Health Services Questionnaire

IMMUNIZATION SCREENING

Please list the date(s) you obtained immunizations/prophylaxis against the following diseases:

		Date	Type	Date unknown	None
Cholera		_____		☐	☐
Diphtheria[1]		_____		☐	☐
Hepatitis A Series:	Dose 1	_____		☐	☐
	Dose 2	_____		☐	☐
Hepatitis B Series:	Dose 1	_____		☐	☐
	Dose 2	_____		☐	☐
	Dose 3	_____		☐	☐
Influenza (most recent only)		_____		☐	☐
Immunoglobulin (IG)		_____		☐	☐
Malaria		_____	_____	☐	☐
Measles, Mumps, Rubella (MMR)		_____		☐	☐
Pneumoccic pneumonia		_____		☐	☐
Polio		_____	_____	☐	☐
Rabies		_____		☐	☐
Tetanus[1]		_____		☐	☐
Typhoid Fever		_____		☐	☐
Yellow Fever		_____		☐	☐

Other: Please provide complete information on Continuation Sheet

[1]May be given as part of TD vaccination

Are you aware of any other medical condition(s) that may affect your suitability for sea duty? No ☐ Yes ☐
If yes, please explain on the continuation page

If you have any questions, please contact the appropriate Health Services Office:
Marine Operations Atlantic (757) 441-6320 **Marine Operations Pacific (206) 553-8704**

Continuation page attached? No ☐ Yes ☐

The information provided is complete to the best of my knowledge.

_____ _____
Signature Date (mm/dd/yy)

Forward to the following ships:

1. _____ 2. _____ 3. _____

MEDICALLY CLEARED FOR SEA DUTY BY HISTORY YES ☐ NO ☐ NEED MORE INFO ☐

_____ _____
MOA/ MOP Regional Director of Health Services Date (mm/dd/yy)

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NOAA Health Services Questionnaire
Continuation Page

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